INJURY DIARY

FOR:

_____

PATIENT NAME

DATE OF INJURY _____

☐ AUTO INJURY

☐ WORK INJURY

☐ PERSONAL INJURY

FROM THE OFFICE OF:

_____

It is important for us to know how you are responding to treatment.

We ask you to make DAILY notations of your pain and your ability to function.

DATE: _____

Today I have had difficulty:

☐ Walking ☐ Standing

☐ Sitting ☐ Bending

☐ Other _____

The pain is affecting my:

☐ Work ☐ Sleep/rest

☐ Other _____

Today my pain has been:

☐ Mild ☐ Moderate ☐ Severe

☐ Constant ☐ Off and On

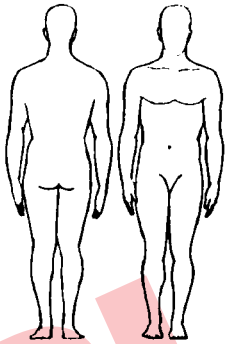
☐ Better ☐ Worse ☐ Same

It is BETTER in the: ☐ Morning ☐ Evening

It is WORSE in the: ☐ Morning ☐ Evening

Remarks:

MARK AREA OF PAIN



BURNING + + + +
STABBING 0 0 0
SHARP / / / / /

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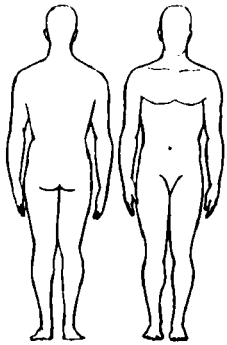

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